Orthopedic Health History

Health History
Entered By: __________
Date: ___/____/_____
For Office Use Only

Today's Date: ____________

Name: ____ Date of Birth: ___________
Age: ___________________________________

Referring Physician: ________________________________ PCP/Family Doctor: __________________________________

List Specialty Providers (Cardiologist, Pulmonologist, etc.): ______________________________________

Pharmacy: ____

Emergency Contact and Relationship: ____ Phone: ___________________

Reason for Visit: (Include Side) ____ Date of Injury/Onset of Symptoms: ______________

CURRENT MEDICATIONS: *If you are not currently taking any medications, please check:*
☐ **SEPARATE MEDICAL SHEET IS ATTACHED** ☐ **ON A PAIN CONTRACT with Dr.________**
(Include OTC vitamins and supplements)

Medication	**Dose**	**Directions (sig)**

Medication Allergies: **Reaction:**

____

____

ALLERGIES: ☐ **NONE**
☐ Latex ☐ Tape ☐ Iodine/Betadine ☐ Birds ☐ Feathers ☐ Eggs

MEDICAL HISTORY: *Please check all that apply or check* ☐ **NONE**

☐ Alzheimer's (Dementia)
☐ Anemia
☐ Anesthetic Problems list:________________
☐ Arthritis _____________________
☐ Asthma
☐ Deep Vein Thrombosis
☐ Cancer: _____________
☐ Congestive Heart Failure
☐ COPD (lung disease)
☐ Coronary Artery Disease

☐ Depression
☐ Diabetes – Type: ____________
☐ Drug Abuse
☐ High Cholesterol (elevated lipid)__________________
☐ Fibromyalgia
☐ Fractures *(what body part & side)* ______________________________
☐ Gout
☐ Hepatitis/liver disease ________
☐ Hypertension (high blood pressure)

☐ Myocardial Infarction
☐ Osteoporosis
☐ Peptic Ulcer
☐ Seizure Disorder
☐ Sleep Apnea ☐ CPAP
☐ Stroke (CVA)
☐ Systemic Lupus
☐ Thyroid Disease
☐ Valvular Disease
☐ Other ____________________

Orthopedic Health History

SURGICAL HISTORY: *Please check all that apply and indicate side and site*

☐ **No Surgical History**

Type of Surgery	Side	Site	Date
☐ Amputation (what body part?)	☐ R ☐ L		
☐ Angioplasty			
☐ Arthroscopy (What Kind?)	☐ R ☐ L		
☐ Back Surgery (What kind?)			
☐ Coronary Artery Bypass Graft			
☐ Cardiac Pacemaker			
☐ Cardiac Valve Replacement			
☐ Carpal Tunnel Release	☐ R ☐ L		
☐ Defibrillator			
☐ Gall Bladder Removal			
☐ Gastric Bypass			
☐ Hip Replacement	☐ R ☐ L		
☐ Hysterectomy			
☐ Knee Replacement	☐ R ☐ L		
☐ Mastectomy			
☐ ORIF/Fractures (with surgery)			
☐ Thyroidectomy			
☐ Other Surgeries			

FAMILY HISTORY: *Please check all that apply or check* ☐ **NONE or** ☐ **ADOPTED**

Father ☐ NONE	Mother ☐ NONE	Brother ☐ NONE	Sister ☐ NONE
☐ Arthritis ___________	☐ Arthritis ___________	☐ Arthritis ___________	☐ Arthritis ___________
☐ Blood Disorder	☐ Blood Disorder	☐ Blood Disorder	☐ Blood Disorder
☐ Cancer ____________	☐ Cancer ____________	☐ Cancer ____________	☐ Cancer ____________
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
Type: ____________	Type: ____________	Type: ____________	Type: ____________
☐ Gout	☐ Gout	☐ Gout	☐ Gout
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis
☐ Other _____________	☐ Other _____________	☐ Other _____________	☐ Other _____________

SOCIAL HISTORY:

Tobacco Use:

☐ **No** ☐ Former

☐ Chew ☐ Cigarettes ☐ Cigar ☐ ePipe

Type: ____________________

Amount/Day: ______________ Years/Use: ___________

Alcohol: ☐ Yes ☐ No

Type: ____________________ Amount & Frequency: ________________________________

Caffeine: ☐ Yes ☐ No

Former Use: ☐ Yes ☐ No

Type: ____________________ Amount & Frequency: ________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Hand Dominance: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Activity Level: ☐ Sedentary ☐ Moderate ☐ Vigorous

Exercise Frequency: ☐ Never ☐ Occasional ☐ 2-3 times/wk ☐ 3-4 times/wk ☐ Daily

Occupation: ________________________________ **Employer:** ________________________________